



A Guide to Medicaid for Migrant Serving Clinicians

Medicaid is a federally-supported, state-administered health insurance program for low-income persons.¹ States design their own Medicaid programs (Medicaid State Plans) and have the flexibility to determine eligibility requirements within certain guidelines. The Medicaid State Plans and any changes or additions must be approved by the Centers for Medicare & Medicaid Services (CMS). Federal matching funds are not capped and total federal funding depends on the overall state program's design and the state's own payments.

General Eligibility Information for Medicaid

Medicaid eligibility is determined by meeting a number of different requirements, including the following: income and resource limits; categorical requirements; state residency; and immigration status.

To meet the **income and resource limit requirements**, an applicant's income and assets must fall under certain thresholds which are often based on the federal poverty guidelines.² States have varying rules on what does or does not count as an asset. In addition, states can increase eligibility levels by "disregarding" certain income;³

Applicants for Medicaid must meet **categorical requirements**, meaning that they must fit within one or more of the eligibility groups, which are based on age (minors and seniors), pregnancy, disability, blindness, or being a member of a family with dependent children. Some beneficiary groups are considered "**mandatory**" and states must cover them. A sample list of mandatory groups includes:

- families that meet the financial requirements of the former Aid to Families with Dependent Children (AFDC) cash assistance program;⁴
- families transitioning from welfare to work for up to 12 months of Medicaid coverage;
- pregnant women and children under age six with family income below 133% of the federal poverty level (FPL);
- children ages six through 18 with family income below 100% of the FPL;

¹ Social Security Act of 1965 Title XIX, 42 U.S.C. §§ 1396-1396v (2006).

² For states with no asset tests required for enrollment of children, see KAISER FAMILY FOUNDATION, *No Asset Tests Required for Medicaid and CHIP, December 2009*, <http://www.statehealthfacts.org/comparetable.jsp?ind=228&sort=290&st=3> (last visited June 7, 2010).

³ For example, see a comprehensive chart of income disregards for New York in 2008, Western New York Law Center, *NY Medicaid Income Disregards Chart* (2008), http://onlineresources.wnylc.net/healthcare/docs/income_disregards.pdf.

⁴ Even though welfare reform in 1996 replaced AFDC with Temporary Assistance for Needy Families (TANF), AFDC income eligibility limits from July 1996 (subject to state modification) apply.

- poor individuals with disabilities or poor individuals over age 64 who qualify for cash assistance under the SSI standard); and

States also have the flexibility to cover “**optional**” beneficiary groups and can qualify for federal matching funds for doing so. Options are specifically delineated by federal law. Some examples of optional beneficiary groups include:

- pregnant women and infants with family income up to 185% FPL;
- children with disabilities whose family income is above the financial standards for Supplemental Security Income (SSI) but below 300% FPL; and
- “medically needy” individuals who meet certain categorical and income levels, from which medical expenses may be subtracted, commonly referred to as “spend down.”

In addition, through a **waiver**, states can cover different, optional categories of individuals who would not otherwise be eligible at all. The goal of state waivers is to provide more flexibility to states to experiment with approaches and adapt to particular needs while still receiving federal funds.⁵ Emergency waivers are also available to aid states with rapid responses, such as provision of temporary Medicaid for Katrina survivors. Finally, many states also have their own **state-funded programs**, funded solely by the state, that complement their Medicaid State Plan, providing care to a wider range of limited income populations not covered under regular Medicaid. For example, Arizona, Delaware, Massachusetts, New York and Vermont provide benefits comparable to Medicaid for non-disabled, childless adults.⁶

Applicants must also meet a **state residency requirement** for Medicaid eligibility, meaning they must apply in the state in which they are a resident. A resident is defined by where one is living with the intent to remain there permanently or for an indefinite period.⁷

Applicants for Medicaid must also fall within **eligible immigrant categories**. Medicaid benefits are restricted to U.S. citizens and certain “qualified” aliens, or fall within another eligible immigrant category, such as certain lawful permanent residents (LPR), asylees/refugees, and certain victims of trafficking or domestic violence who have approved or pending applications for immigration status, among others.⁸ Further, to be eligible for Medicaid, many “qualified immigrants” must have held their “qualified” status for five years unless they entered the country before August 22, 1996.⁹ The five-year bar does not apply to some categories of immigrants, such as refugees/asylees and those serving in the military. Also, states have the option of providing Medicaid to children under 21 and to pregnant women without the 5 year bar. As of 2009, the following states cover LPR children without the five-year waiting period:

⁵ 42 C.F.R. § 430.25 (2009).

⁶ See KAISER FAMILY FOUNDATION, *Medicaid Waiver and State-Funded Coverage Income Eligibility Limits for Childless Adults, 2009*, <http://www.statehealthfacts.org/comparetable.jsp?ind=749&cat=4> (last visited June 7, 2010).

⁷ 42 C.F.R. § 435.403 (i)(1)(i)-(ii) (2009) (regarding non-institutionalized individuals over the age of 21). Although the second part of the provision, § 435.403 (i)(1)(ii) concerning entering with a job commitment or seeking employment exists, the 435.403(i)(1)(i) seems by far to be the prevalent common standard.

See 42 C.F.R. § 435.403 for complete regulations on residency requirements.

⁸ Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), Pub. L. No. 104-93, 110 Stat. 2105 (codified as amended at 8 U.S.C. §§ 1601-46 (2006)).

⁹ 42 U.S.C. § 1613 (2006).

CA, CT, DC, HI, IL, IA, ME, MD, MA, NJ, NM, NY, OR, PA, RI, VA, WA.¹⁰ States may also provide pregnant women prenatal care without regard to their immigration status. See the National Immigration Law Center’s charts for a helpful overview of immigrant eligibility for Medicaid and additional state coverage.¹¹

Applicants for regular Medicaid who claim to be U.S. citizens must also furnish proof of U.S. citizenship and identity. This controversial new requirement has increased barriers to Medicaid, resulting in enrollment declines and increased administrative burden.¹²

Emergency Medicaid is available to all persons regardless of immigration status or length of residency, as long as they meet the other regular eligibility requirements. The federal Medicaid Act’s definition of an “emergency medical condition” is:

a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

- (A) placing the patient's health in serious jeopardy,
- (B) serious impairment to bodily functions, or
- (C) serious dysfunction of any bodily organ or part.¹³

The implementing federal regulation adds the element of “sudden onset” of an emergency medical condition,¹⁴ so usually chronic conditions are not covered unless they become extreme. Treatments for cancer, such as chemotherapy, have become particularly controversial, with some states such as New York providing full Medicaid coverage for chemotherapy using solely state funds.¹⁵ Emergency coverage specifically excludes organ transplant procedures.¹⁶

¹⁰ States have the option to cover recent LPR children and pregnant women. See NATIONAL IMMIGRATION LAW CENTER, *Table 10: Medical Assistance Programs for Immigrants in Various States* (Feb. 24, 2010), available at <http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-02-24.pdf> (describing state programs—CHIP-funded and exclusive state-funded—that provide for coverage of lawfully residing children and pregnant women no matter the date of entry, and prenatal care to women with any status); see also Children’s Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3 (2009) (codified in various sections of 42 U.S.C.). In addition, Express Lane Eligibility provides a streamlined process using shared information with other public programs, such as WIC and school lunch programs, to provide children with wider access to health coverage.

¹¹ NATIONAL IMMIGRATION LAW CENTER, *Table 1: Overview of Immigrant Eligibility for Federal Programs* (Apr. 8, 2010), available at http://www.nilc.org/pubs/guideupdates/tbl1_ovrvw-fed-pgms-rev-2010-04-08.pdf; *Medical Assistance Programs for Immigrants in Various States* (Feb. 2010), available at <http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-02-24.pdf>.

¹² U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-07-889, *MEDICAID: STATES REPORTED THAT CITIZENSHIP DOCUMENTATION REQUIREMENT RESULTED IN ENROLLMENT DECLINES FOR ELIGIBLE CITIZENS AND POSED ADMINISTRATIVE BURDENS* (June 28, 2007), <http://www.gao.gov/new.items/d07889.pdf>

¹³ 42 U.S.C. § 1396b(v)(3) (2006).

¹⁴ See 42 C.F.R. § 440.255(b) (2009) (emphasis added).

¹⁵ Sarah Kershaw, *U.S. Rule Limits Emergency Care for Immigrants*, N.Y. TIMES, Sept. 22, 2007, <http://www.nytimes.com/2007/09/22/washington/22emergency.html>; New York Dep’t of Health, *Medicaid Reference Guide - November 2009*, http://www.health.state.ny.us/health_care/medicaid/reference/mrg/november2009/page457.pdf.

¹⁶ 42 U.S.C. § 1396b(v)(2)(c) (2006).

Generally, emergency Medicaid coverage begins at the start of treatment and continues until the point when the condition is deemed no longer an emergency. The determination of “emergency medical condition” varies from state to state.¹⁷ Determinations of what constitutes an “emergency medical condition” can be confusing, particularly where illnesses or injuries span long periods of time or when acute symptoms recur.¹⁸ Whether a condition is considered an emergency can depend on the duration of the treatment as well as the site of treatment. In Illinois, for example, an emergency medical condition is limited to treatment in an emergency room, critical care unit or intensive care unit, and services can only be authorized for 30 consecutive days, outside of a rare situation.¹⁹ In New York, however, treatment is not site-specific and emergency care can last up to 90 days, after which one can obtain new certification for subsequent or continuing treatment.²⁰ Several states, including California, Massachusetts and Washington, have pre-qualification cards that noncitizens can obtain and renew after various time periods. Legal Momentum has a breakdown of state laws concerning emergency Medicaid, as well as application process information, current as of September 2007 at http://www.legalmomentum.org/assets/pdfs/4_emergency_medicaid_chart.doc.

Medicaid coverage can begin retroactively up to three months prior to the application if one would have been eligible during that time. Presumptive coverage is also available for pregnant women, children, and some breast or cervical cancer patients. Medicaid coverage generally concludes at the end of the month in which a person’s circumstances changed (such as a move to a different state, income increase, or a change that takes one out of an eligibility group).

Barriers for migrant and seasonal farmworkers

Migrant and seasonal workers face many barriers in gaining access to Medicaid benefits. Many farmworker are ineligible for Medicaid because they may fall under the widely non-covered class of non-disabled, childless adults²¹ or because they do not have “qualified” immigration status for the requisite five-year period. With respect to the application process, income and asset tests may prove difficult for migrant workers, who have fluctuating incomes and may lack paystubs or other proof of income. Seasonal earnings may result in an inaccurate estimate of average annual income resulting in ineligibility, although some states, such as Wisconsin, permit seasonal earners to calculate annual income using anticipated earnings. Asset tests may also pose challenges for farmworkers, as they may own assets such as vehicles that are

¹⁷ See KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *Summary: Five Basic Facts on Immigrants and their Health Care*, Kaiser Commission on Key Facts (March 2008), available at <http://www.kff.org/medicaid/upload/7761.pdf>.

¹⁸ See Janet M. Calvo, *The Consequences of Restricted Health Care Access for Immigrants*, 17 ANNALS HEALTH L. 175, 184-91(2008).

¹⁹ Illinois Dep’t of Human Servs., <http://www.dhs.state.il.us/page.aspx?item=19608>.

²⁰ NY Health Access, Western New York Law Center, *Emergency Medicaid in New York State*, <http://wnylc.com/health/download/94/> (2010).

²¹ See MICHAEL O. LEVITT, SECRETARY OF HEALTH AND HUMAN SERVICES, REPORT TO CONGRESS: STUDY REGARDING BARRIERS TO PARTICIPATION OF FARMWORKERS IN HEALTH PROGRAMS 5 (2006), available at <http://www.cms.gov/reports/downloads/RTC-Leavitt2.pdf> (describing the predominantly male workforce and differences in health care utilization compared to females).

necessary for employment, but that could result in ineligibility due to the asset limits.²² Finally, practical problems arise in accessing Medicaid, such as lack of transportation, time, and familiarity to carry out the application process; language access barriers (more below); the length of time for eligibility determination; and fears concerning confidentiality and immigration status of individuals and family members.

Language Access

Despite federal laws requiring entities receiving federal funds to provide language services to limited English proficient persons, language access remains a significant barrier for many farmworkers. The majority of farmworkers speak Spanish; however, increasing numbers of farmworkers speak indigenous languages such as Mixteco and Kanjobal, and many farmworkers also speak Haitian Creole.²³ Some efforts have been made to address this problem. HHS, in accordance with Executive Order 13166, has developed policy guidance to help ensure language access.²⁴ In addition, all states also have health-care related language access laws.²⁵ Notably, California has comprehensive language access provisions, and Maryland and Washington D.C. have developed language access laws for state agencies.²⁶ Some states have funding laws to provide for language access services. For example, Texas has a Language Interpreter Service Pilot Program funding language services for Medicaid, and Connecticut provides for Medicaid payments for language services.²⁷ Minnesota has been active in language access efforts, developing certification standards for its interpreters as well as reimbursing Medicaid providers for language services.²⁸

Portability and Presumptive Eligibility

Because the system is state-administered, Medicaid generally lacks portability (or transferability) of benefits from one state to another. Because many farmworkers move from state to state several times during a year, Medicaid's lack of portability greatly limits their access to Medicaid and creates a significant barrier to services.

Migrant workers and their families can apply for Medicaid in the state of their permanent residence or the state in which they are working or pursuing work. In most cases, migrant

²² See Sara Rosenbaum & Peter Shin, KAISER FAMILY FOUNDATION, *Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care* 3 (April 2005), <http://www.kff.org/uninsured/upload/Migrant-and-Seasonal-Farmworkers-Health-Insurance-Coverage-and-Access-to-Care-Report.pdf>.

²³ Nat'l Agricultural Workers Survey, *Native Language*, 2001-2002, <http://www.doleta.gov/agworker/report9/toc.cfm>. See also National Center for Farmworker Health, *Migrant and Seasonal Farmworker Demographics*, www.ncfh.org/docs/fs-Migrant%20Demographics.pdf.

²⁴ See U.S. Dep't of Health & Human Services, *Guidance to Federal Financial Assistance*, Rev. 2003, <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>.

²⁵ Melanie Au, Erin Fries Taylor & Marsha Gold, *Improving Access to Language Services in Health Care: A Look at National and State Efforts*, April 2009, located at www.ahrq.gov/populations/languageservicesbr.pdf (last visited June 24, 2010).

²⁶ Jane Perkins & Mara Youdelman, National Health Law Program *Summary of State Law Requirements Addressing Language Needs in Health Care*, March, 2008, 5- 6, <http://www.healthlaw.org/images/stories/issues/nhelp.lep.state.law.chart.final.0319.pdf>.

²⁷ *Id.* at 6.

²⁸ See www.dhs.state.mn.us/language/default.htm for more information.

farmworkers would need to re-apply for Medicaid each time they move to a new state.²⁹ Because farmworkers cannot be enrolled in more than one state's Medicaid program, issues may arise concerning disenrollment from a state program as well. Without disenrolling and reapplying in each state, farmworkers are limited to emergency Medicaid coverage. Even for farmworkers who do manage to complete the application process in each new state, they must still wait upwards of 45 days to receive a determination of eligibility and face a lapse of coverage during this time.³⁰ No provision exists for expedited Medicaid applications.³¹

There are limited provisions, such as presumptive eligibility, to provide transitional or immediate coverage before an application for Medicaid is approved; but they are available only to very few specific categories of people. For example, states can choose to provide presumptive eligibility for low-income pregnant women, children, and some breast or cervical cancer patients.³² Presumptive eligibility starts on the date on which a qualified provider, using preliminary information, determines eligibility based on the state plan's income limits. The beneficiary can retain coverage if found eligible through the regular application process. The end of presumptive eligibility falls on the date when regular eligibility is determined or the date of coverage termination if no application is filed within sixty days.

Two states have developed responses to the portability problem—Texas and Wisconsin. Texas has established a Migrant Care Network (MCN) providing portable coverage for migrant farmworkers who travel out of state.³³ Currently enrolled out-of-state providers are located in IN, MD, MI, MN, NY, OK, OH, SC, WA and WI.³⁴ Under MCN, out-of-state health care providers enroll in Texas's Medicaid program and are reimbursed for services, similar to how an HMO covers out-of-state care. The beneficiary must be enrolled in Texas prior to leaving for out-of-state employment.

Wisconsin's health care system provides for Medicaid reciprocity for migrant farmworkers receiving Medicaid in other states. Currently, migrant workers who already have coverage in other states are eligible for Wisconsin Medicaid or its state program BadgerCare Plus (which provides expanded coverage to more children and non-disabled, childless adults) by

²⁹ Minimum state residency time periods are not allowed in determining Medicaid eligibility. See U.S. DEPT OF HEALTH & HUMAN SERVICES, *HRSA Medicaid Primer*, (rev. Dec. 2000), available at <http://www.hrsa.gov/medicaidprimer> (“[M]igrant workers and their children are able to qualify on the same terms as any other person in a specific State.”).

³⁰ 42 C.F.R § 435.911 (2009). Depending on the applicant's class, this time frame will differ. For example, in Georgia, the time frame for pregnant women is ten days, while for disabled applicants it is 60 days. GEORGIA DEPT OF HUMAN SERVICES, *How Do I Apply for Medicaid?*, <http://www.dfcs.dhr.georgia.gov/> (last visited June 7, 2010).

³¹ 42 C.F.R § 435.911 (2009). Depending on the applicant's class, this time frame will differ. For example, in Georgia, the time frame for pregnant women is ten days, while for disabled applicants it is 60 days. GEORGIA DEPT OF HUMAN SERVICES, *How Do I Apply for Medicaid?*, <http://www.dfcs.dhr.georgia.gov/> (last visited June 7, 2010).

³² 42 U.S.C. §1396r-1 (2006) (presumptive eligibility for pregnant women); 42 USC §1396r-1a (presumptive eligibility for children); 42 U.S.C §1396r-1b (2006) (presumptive eligibility for certain breast or cervical cancer patients).

³³ For more information, see TEXAS MIGRANT CARE NETWORK, *Overview*, <http://www.tachc.org/Programs/TMCN/Overview.asp> (last visited June 7, 2010).

³⁴ See TEXAS MIGRANT CARE NETWORK, *Enrolled Providers*, (Mar. 26, 2010), available at <http://www.tachc.org/Programs/TMCN/Enrolled%20Sites%202003-26-2010.pdf>

filling out a simplified application that does not require financial information.³⁵ Migrant workers with no current coverage in any state can apply with a regular application that calculates financial eligibility using annualized income (as opposed to an estimate taken from one month's actual income or other methods that do not take into account fluctuating income levels).

Health Care Reform

The Patient Protection and Affordable Care Act (PPACA)³⁶ establishes a new coverage group of low-income individuals (incomes below 133% of the poverty line who are under the age of 65, not pregnant, not enrolled in Medicare, and not eligible under any other mandatory Medicaid coverage group).³⁷ The income test for this group does not consider assets in determining eligibility. While coverage of this group is not mandatory until January 2014, states have the option to cover all or a portion of this group starting April 1, 2010. In April, Connecticut announced its plan to expand Medicaid coverage to childless adults (currently covered under the state-sponsored State Administered General Assistance program).³⁸ If the plan is approved under PPACA, coverage would be retroactive to April 1, 2010. In mid-May, Washington, D.C. also submitted a state plan amendment to expand Medicaid under PPACA.³⁹

The contents of this publication are solely the responsibility of Farmworker Justice and Migrant Clinicians Network and do not necessarily reflect the official views of the Bureau of Primary Health Care or the Health Resources and Services Administration.

³⁵ See STATE OF WIS. DEP'T OF HEALTH SERVICES, *Medicaid Eligibility Handbook* (Apr. 2, 2010), available at <http://www.emhandbooks.wi.gov/meh-ebd/>; STATE OF WIS. DEP'T OF HEALTH SERVICES, *Badgercare + Eligibility Handbook* (Feb. 25, 2010), available at <http://emhandbooks.wi.gov/bcplus/>; WIS. DEP'T OF HEALTH SERVICES, *Wisconsin Medicaid and Badgercare Fact Sheet – Medicaid for Migrant Workers*, <http://dhs.wisconsin.gov/medicaid/Publications/p-10053.htm> (last visited June 7, 2010) (“If you are getting Medicaid in another state, you can get Wisconsin BadgerCare Plus for Families or Medicaid if you have the same number of people in your home as when you were enrolled in the other state.”).

³⁶ See Patient Protection and Affordable Care Act (PPACA) § 2001, Pub. L. No. 111-148 (2010).

³⁷ In April, CMS also issued an initial guidance letter (one of a series) on Sec. 2001 of PPACA. See Center for Medicaid and State Operations, *New Option for Coverage of Individuals Under Medicaid* (Apr. 9, 2010), available at <http://www.cms.gov/smdl/downloads/smd10005.pdf>.

³⁸ STATE OF CONN. DEP'T OF SOC. SERVICES, *Governor Rell: Connecticut Seeking New Federal Health Care Dollars*, Apr. 16, 2010, <http://www.ct.gov/dss/cwp/view.asp?Q=458714&A=2345> (last visited June 7, 2010).

³⁹ Darryl Fears, *D.C. Jumps at Health-Care Savings in Expanded Medicaid*, WASH. POST, May 14, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/05/13/AR2010051304995.html>.